Title: Rehabilitation Counselling:The quest for professional relevance

Author: Dr Herbert C Biggs
Senior Lecturer
School of Psychology and Counselling
Queensland University of Technology
Beams Rd
Carseldine Qld 4034
Ph: 07/3864 4772
Fax: 07/3420 5189
Mob: 0438 342052
Email: h.biggs@qut.edu.au

Abstract:
The global community is experiencing widespread and rapid changes to labour force participation with increasing expectations of flexible and highly adaptable skill sets. Workers can expect demands to acquire new and augment existing competencies as an integral part of he labour contract. Continuing education, professional development, competency augmentation, and lifelong learning are the occupational mantras of the Millennium. If this is an expectation within the workforce, what then are the expectations of support professionals such as rehabilitation counsellors who expect to exercise considerable skill at client workforce re-entry? This paper examines a range of issues for ongoing skilling and provides a set of recommendations for ongoing contemporary professional relevance.

Bill Jenkins and David Strauser (1999) recently intrigued the rehabilitation counselling profession with a call for the profession to horizontally expand its interaction with business and organisations. The general thrust of the argument was that, although rehabilitation counselling has been identified as providing specific services to people with disabilities, the rehabilitation counsellor's knowledge, skills, and service delivery are comprehensive and applicable to almost any group, including people who do not meet the definition of having a disability. They further believe that the marketability of rehabilitation counsellors will suffer in the future if they remain niche players serving a single, identified population. Business will be more inclined to hire rehabilitation counsellors who use a broader service approach geared to increase productivity of the labour force in general. What are the drivers here?

The Australian workforce and labour markets are undergoing rapid change as part of the global economy. New paradigm shifts are occurring that will shake traditional notions about how people earn a living and participate in the world of work. Corporate perceptions and expectations of the labour force are changing as the corporate world becomes focused on international competition and profits that ensure survival. The challenges are evident and palpable. For example the recent entry of China into the World Trade Organisation can be viewed through two prisms. The commodity producing west may see an additional 1.5 billion consumers of their products, but China may see no such thing and instead anticipate marketing their products to a hitherto inaccessible 2.5 billion consumers.
Goldstein (1996) notes that labour market changes are occurring both demographically (e.g. ageing workforce, internal population migrations) and structurally (e.g. service industries over manufacturing, information and engineering technology including robotics, deregulation and tariff reductions, corporate mergers and downsizing, Internet applications, outsourcing, and increased competition). Additional issues impacting today's labour force include increased emphasis on health and safety, legalism and litigation (e.g. public use insurance), workforce morale, child and elder care, work place bias, creative benefits, quality of work life, job redesign,

and need for flexibility and adaptational skills, and finally emphases on lifelong learning. These changes are so substantial that Jenkins and Strauser (1999) consider them a paradigm shift.

What does a workplace paradigm shift mean for rehabilitation professionals?
A paradigm shift invariably involves dislocation, conflict, confusion, and uncertainty. New paradigms are nearly always perceived with coolness, scepticism, through to mockery or hostility. Those with vested interests resist the change. The shift demands such a different view of things that established leaders are often the last to be won over, if at all. Strong resistance is likely on the part of workers directly affected, as well as from a myriad other players including professionals who share the responsibility of helping others adapt to changes. Thus the rehabilitation professional is likely to be working in a transitionally leaderless environment, communicating with hostile workers, interacting with distant and resistant fellow professionals, and seeking structure in a very fluid organisational environment.
Dare I even mention the sorts of skills that keep you afloat in that environment?!
Changes currently occurring that will determine where and how rehabilitation counsellor's work include, among others, the concept of a placeless society. The placeless society is defined as a world of everything and everybody being at once everywhere (Knoke, 1996). According to Knoke (1996), we are already seeing the beginning signs: For example banks that serve any customer from any branch in cyber transactions, supermarket chains that know the minute-by-minute sales of any cash register in any location and can tag your preference for a commodity and market that instantaneously at point of sale, airlines that electronically link hundreds of thousands of retail travel offices into its flight schedules and tariffs, and WAP assisted phones and devices that put you tantalisingly equally close to both consumer heaven and debtor hell.
Unlike the United States environment in which Jenkins and Strauser bed many of their comments, Rehabilitation Counsellors in Oceania typically provide services in the areas of disability management, job development and placement, and worker's compensation. However these services are arguably the types of services that are

vulnerable as discrete siloed services in today's economic conditions and business climate. Organisations are likely to seek a consolidation of these services to be provided by one broad-based organizational consultant. Such a consultant's comprehensive service could include job design, work flow analyses, organizational development, as well as disability-related issues. In other words rehabilitation counsellors need to broaden the application of their knowledge to non-disability related areas within organizations and incorporate new areas of knowledge into their training.

One useful bridging technique has been advocated by Gilbride, Stensrud and Johnson (1994) who suggest that we investigate demand-side job development the focus of which is to assist employers in meeting their workforce needs by employing individuals with disabilities. The goals of the demand-side job development model are to increase the number and types of positions that individuals with disabilities obtain and to assist employers in developing an effective recruitment strategy for individuals with disabilities. There are several components to the model including 1) increasing demand; 2) consultative approach; 3) employer need focus; 4) job focused; 5) private funding; 6) on-going consultation; 7) service is imperative; 8) financial bottom line; and 9) universal help, but let's look at a two components that make the model progressive and perhaps give us a glimpse of a way ahead where the rehabilitation counsellor has a progressively important role in meeting the needs of the employer.
First, in the demand-side job development model, rehabilitation professionals are called upon to develop a consultative approach and to assist employers in meeting human resource needs. This suggests a need for rehabilitation professionals to play a role in organizational development and workflow design. As suggested earlier employers are likely to favour consultants who can provide comprehensive employment services and are knowledgeable about work design, staffing issues, disability, workers' compensation, and organizational design and development. Niche players are likely to be viewed as too specialised and an individual with broader based expertise will more likely provide a value-added service to the company.
Second, the demand-side job development model focuses on employer needs. Quite

often rehabilitation professionals are unaware or possibly unconcerned with the employer's needs. According to the model, rehabilitation professionals must possess an understanding of the company and how the work is done within that enterprise. Focusing on employer needs leads to ongoing consultation which develops and sustains genuine contact on matters of critical importance to the employer. There is a shared understanding of the enterprises goals and the increased potential for any challenges or opportunities faced to be referred first to partners in that prime relationship or at the very least an offer of first refusal made.

In addition, and by way of extension of Jenkins and Strauser's view, there are two developments that could usefully occur.

First, Rehabilitation counsellors could develop their body of knowledge in areas of organizational behaviour and management. A cursory glance in our own working environments in Australia will determine that rehabilitation counsellors are not the only professionals conducting job analyses and assisting companies with disability management issues. In truth many organizations view these activities as a function of human resource management and staff accordingly. If our tertiary educational curricula or continuing education components for the training of rehabilitation counsellors don't already so emphasise we should be maintaining knowledge in recruitment and selection, job design and organisational development, organisational culture, economics, salient features of work motivation, job satisfaction, and human resource management generally.

Second, the roles and functions of rehabilitation counsellors have long been the subject of attention, but this attention is episodic and typically reactive. ASORC have been previously active in this field and have done laudable work in compiling skills and competencies for the guidance of Australian Rehabilitation Counsellors. This work now needs to be extended using contemporary mapping techniques to regularly chart comparisons with other professionals such as human resource managers, industrial organizational psychologists, human factor specialists and professional managers who are involved in organizational behaviour and job design. These assessments will help rehabilitation counsellors obtain a clear and accurate ongoing

understanding of how rehabilitation counselling compares to other related professions. Rehabilitation counselling may be a unique profession if summated by the collection of skills that describe it, but it is not difficult to observe other professionals engaging in activities that rehabilitation counsellors might have thought unique to their profession. Skill sets are not static nor are they typically uniquely possessed. Contemporary mapping will enable rehabilitation counsellors to see potential opportunities with some clarity; namely, the potential for applying their skills to areas outside traditional rehabilitation counselling, and gaps, previously suggested, in which rehabilitation counsellor education might usefully augment its curricula.

I have mentioned additional skilling gleaned form the organisational environment that could usefully augment the rehabilitation counselling profession, but what are some skills closer to home that we could fine tune?

Back to the basics – Counselling interventions

Narrative therapy is an emerging and useful intervention on which Elaine Nuske and I have reported at a previous ASORC Conference (Biggs & Nuske,1999). Narrative therapy has been largely pioneered by Michael White and David Epston (1991) both of whom are family therapists practising in Australia. They have developed a theory of practice which, they suggest, empowers clients to move away from a blaming, circular view of their life to a vision of the future embodying rich and more meaningful alternatives, and allows greater control of their lives in ways previously deemed unattainable. Their work is based on discourses grounded variously in the work of social science research, post-modernism, cognition theory, and identity theory. They were concerned that their clients were constantly engaged in their life stories focusing on blame, attack, recrimination, and judgment. They saw narrative therapy as giving a pathway out of this passage. By focusing clients on subtle changes that accompany problem movement and definition, clients were able to address new insights and were able to be creative and clear in addressing future outcomes.

There have been a number of practice issues in the literature indicating the powerful potential of narrative therapy for the role of the rehabilitation counsellor. Time limits a discussion of two examples. Polkinhouse (1996) studied ‘life plots’ that clients

create that are either vitimic (implications of blame, retribution and lack of movement) or agentic (fully energised and directed towards a goal). By using White and Epston's framework of narrative therapy, clients can remove themselves from the story, reflecting on how they have become the victim, and change the circumstances of the story by recalling previous life situations where actions were more effective e.g. if a client is unable to be a father in terms of playing football with his son - then circumstances could be changed reflect father watching son play. Nochi (1998) studied people who had suffered traumatic brain injuries in terms of narratives and sense of identity. He interviewed 10 individuals who had all sustained TBI from a motor vehicle accident or sports injury between 2 to 12 years previous, in term so their sense of loss of self as indicated through their narratives. He identified three types of loss of self, notably loss of clear self knowledge, loss of self as defined by comparison with their past, and loss of self as defined by others. By discovering which area was most significant for the patient it was possible for the professionals to plan interventions accordingly. Narratives were used to help the client deal with the loss of self experience, thus individuals could transform the self narrative in which the 'problem' is embedded in the self. Once the individual identifies that the 'problem' is not him or her self and as such unchangeable, then the sense of powerlessness is gone.

Thus the client is helped to see that he/she *has* a problem rather than *is* a problem thus becoming less depressed as the sense of helplessness is reduced.
Narrative therapy has tremendous application to a rehabilitation forum. Traumatic illness events that throw lives into turmoil and force individuals to reassess their life path and expected life outcomes can benefit by the process of externalisation of the 'problem'. This is achieved by a consideration of strengths and gains made throughout life that can be renegotiated in terms of new self identities, by considering outside environmental changes and by considering alternate perspectives and alternate realities for future orientation. This can be incorporated within a more traditional goal and problem focused theoretical base of therapy, and can add depth and richness, allowing the client to attain a sense of control and power over what has become a

disempowered existence. The presence of ‘sparking moments’ to use the terminology of Michael White makes this a vigorous and energising therapeutic environment. Finally, Australia has an ageing population with predicted longer life spans. Narrative therapy is particularly suited to elderly discourse with its extensive base of experience and rehabilitation Counsellors would do well to equip themselves to provide appropriate counselling services to this population as this may well be where the market shifts in the not too distant future.

Brief therapy is an additional useful technique which has developed into a pervasive model of therapy in human service settings. The distinguishing feature of brief therapy is the incorporation of a time limit as one aspect of the service contract between the interacting participants. Brief therapy is short term by design and not by default and the deliberate use of the time limit distinguishes this form of therapy from unplanned short term therapy. Once viewed as a superficial and expedient treatment to be used only in emergency situations until long term therapy could begin, brief therapy is now being considered as the most appropriate treatment for a substantial number of clients. Several factors have contributed to this shift from long-term to short-term treatment. Firstly, the impact of managed care and its derivatives on service delivery patterns; secondly, budgetary constraints in the welfare and social services sector; and thirdly, recognition that short-term treatment is the treatment of choice for specific problems. The predominant focus of the therapy is problem or solution focused. By client and therapist exploration of amplification of exceptions to the problem, solutions may evolve and problems be left behind. Rather than focusing on the occurrence of the problem, clients are encouraged to predict when they are likely to overcome the urge to engage in the problem behaviour and are then asked to account for the accuracy of their prediction. A focus is on the basic principle that predicting exceptions tends to increase the frequency of the predictions. Such tasks of predicting random exceptions are designed to create a self-fulfilling prophecy.
A further focus in brief therapy is what has been described as "strengths perspective" (Saleebey, 1992). This perspective rests on several assumptions the most notable of which accept that all persons possess strengths that can be harnessed to improve the

quality of their lives, a focus on ability and strengths de-emphasises a "blame the victim approach", and that all environments, even the most bleak, contain some resources which may be accessed. These assumptions are grounded in the post structural notion that the client's "meaning" must count for more in the helping process, and scientific labels and theories must count for less. Finally a further focus of brief therapy is the development of well-formed goals.

Brief therapy with its substantial pedigree across psychodynamic and cognitive behavioural domains, and with an emphasis on goal oriented solutions, represents a conceptual and practice model that meets a very significant contemporary rehabilitation counselling environment. There is a suspicion, but little hard evidence to date, that rehabilitation counsellors are in fact using such a therapeutic model but remain unaware of its antecedents or theoretical base. If this is the case we need to professionalise our approach to the use of such a therapy, become expert in its application, and incorporate it into our skill and competency set.

Play to the strengths – Vocational evaluation and assessment

Stephen Thomas (1999) notes that within rehabilitation and transition service delivery models, concepts of empowerment (informed choice, self-determination), and career development have given consumers more influence in decision making and greater control over planning their own futures. Information is empowering and vocational evaluation provides consumers with the resources to make "informed choices." These philosophical transformations in rehabilitation are occurring at a time when society is also experiencing changes in the nature of employment and the value of work

Rehabilitation Counsellors, particularly in Oceania, have traditionally undertaken vocational evaluation and assessment – a role subsumed in the US by Vocational Evaluators. This role could be usefully differentiated into two discrete functions for market need. The two roles are vocational/career expert; and disability specialist. Vocational/career expertise has always been the focus of a rehabilitation counsellor’s attention and career, occupational, and labour market information are primary tools. It is important that the vocational evaluation and assessment process not be viewed as a rehabilitation service for a few but as a career development service available to

anyone. Second, rehabilitation counsellors should market their skills as disability specialists as has traditionally been the case and the constituency will remain ostensibly the largest to be served. However this also serves to demonstrate a level of depth, flexibility, and sensitivity on the part of the professional that will benefit anyone using the service.

What are the potential in this area of vocational assessment and evaluation?
A clear direction would be the provision of career assessment exploration, and development services for people with disabilities and the general public. This could focus more on addressing the necessary balance between job/career and avocational/offwork activities in an attempt to improve overall quality of life. This focus on career-life satisfaction throughout the lifespan will promote the re-evaluation of consumers as they seek additional assistance with career direction in the future.
A further direction would be to provide a professional and expert patina to the current surge in life coaching and lifestyle planning. Although both issues tend to emphasise goal attainment and quality of life issues, many reflect a vocational or career aspirational set if at the very least to purchase the desired goals. This area is burgeoning and sorely lacking in trained professionals. And at the risk of repeating a left field activity of the type that Diane Jackson and I suggested had merit at the last ASORC Conference (Biggs & Jackson, 2001) can I state that there are no better trained professionals than rehabilitation counsellors to facilitate goal setting, program maintenance, and motivational behaviours in human services. Perhaps it has been avoided because of a perception that it represents indulgent wish fulfilment rather than real and compelling social need, and for many professionals steeped in social justice and welfare equity the thinking is understandable. However, modern life does provide opportunities and challenges and for many the resources to pursue them. A professional fee paying service is something we have long observed in cosmetic surgery, and fashion usually without demure. There are real opportunities for skill application in the client personal achievement domain. The skills are there, the use of them is valid and complementary to our typical core business – the challenge is yours.
REFERENCES

Biggs, H. C. & Jackson, D. (2001). Compulsivity and addiction in the workplace: employer and employee responsibilities and rehabilitation management of cybersex addiction. *Proceedings of the Australian Society of Rehabilitation Counsellors: Cents and Sensibility Conference*. Surfers Paradise Marriott Resort. Gold Coast, Australia.

Biggs, H. C. & Nuske, E. M. (1999). A tale of two therapies. Proceedings of the 4th National Conference of the Australian Society of Rehabilitation Counsellors, (pp. 142-159). ASORC, Coffs Harbour, NSW, Australia

Gilbride, D., Stensrud, I. L, & Johnson, M. (1994). Current models of placement and employer development: Research and competencies and educational considerations. *Rehabilitation Education, 7*, 215-239.

Jenkins, W. & Strauser, David, R. (1999). *Journal of Rehabilitation. 65 (1)*, 4-10.

Nochi, M. (1998). Loss of self in the narratives of people with traumatic brain injuries: A qualitative analysis. *Social Science Medicine, 46(7)*, 869-878.

Polkinhouse, D. E. (1996). Transformative narratives: From victimic to agentic life plots. *The American Journal of Occupational Therapy, 50(4)*, 299-305.

Salleebey, D. (1992). *The strengths perspective in social work practice*. New York: Longman.

Thomas*, S. W* (1999). *Journal of Rehabilitation*, 65 (1), 10-16.

White, M., & Epston, D. (1991). *Narrative means to therapeutic ends. New York:* WW Norton.